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ABSTRACT

This paper reflects on lessons learned from the implementation of KAN Focus, a demonstration project to develop a system of care for children with severe emotional disturbance in rural southeast Kansas. It notes trends toward providing more and younger children with community-based support services which provide family centered services, short-term, targeted approaches such as information and advocacy for parents, case management, attendant care, and home-based family therapy. Outcome data in Kansas are reported to show that children are progressing more rapidly, completing services sooner, and returning to services less often. A review of research found that when the primary risk factors are poverty, single family homes, and lack of medical care, health- and education-focused home visitation programs can have dramatic positive effects. However, when the same risk factors are accompanied by mental illness, substance abuse, or family violence, success rates of such programs are much lower. Three specific lessons from the Kansas effort are discussed: (1) systems of care for young children are very different than the ones for children and adolescents with severe emotional disturbance; (2) collaboration is worthwhile but hard work; and (3) good program evaluation improves collaboration, service effectiveness, cost efficiency, and sustainability. (DB)

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Lessons from the Village: Early Intervention and Prevention

Introduction

This summary describes early inductive research to identify variables important to the development of systems of care for families that include young children at high risk of abuse, mental illness, substance abuse, and future criminal behavior. The federal Center for Mental Health Services (CMHS) demonstration project, *Kan Focus*, began in October 1994 to develop a system of care for children with SED in rural southeast Kansas. During the year prior to the implementation of *Kan Focus*, the average age of admission of children into mental health services was almost 16 years of age. Three years later, in the period between November and March 1997 the children's average age at admission had decreased to 11 (see Figure 1). Experience with the *Kan Focus* project suggests that establishing truly collaborative systems of care is very difficult and rarely accomplished. This summary addresses lessons learned and strategies that may be important to improving community collaboration and establishing systems of care around families with very young children. These findings are shared to expand the dialogue on identifying key variables in the development of such systems.

More and more younger children are receiving community-based support. As strength based and family centered services begin earlier, teams can utilize short-term, targeted approaches such as information and advocacy for parents, case management, attendant care, and home based family therapy. These supports

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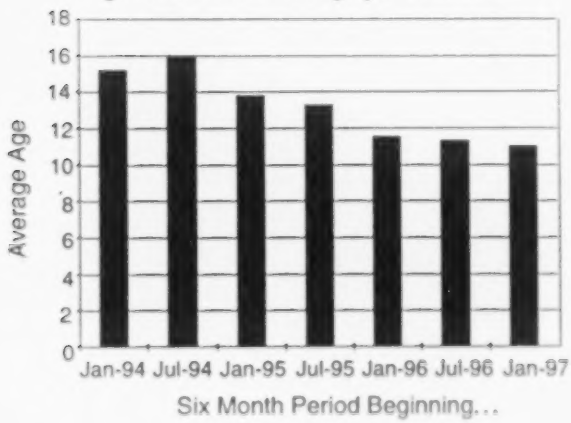
allow families to stay in control, and offer children a much improved prognosis for positive futures. Outcome data in Kansas show that children are progressing more rapidly, completing services sooner, and returning to services less often. Parents and teachers have long known the signs and symptoms of emerging emotional and behavioral problems; once community-based mental health services had demonstrated success and were available for younger children with less severe problems many families began to access them.

In conjunction with this movement toward early intervention, *Project Before* reviewed available research to identify risk factors that greatly increase the probability that a child will be abused, placed out of his home, and have mental illness, substance abuse, and criminal problems. It is important to note, however, that children who have certain protective factors are often buffered from high-risk situations and have good outcomes. The treatment research shows that when the primary risk factors are poverty, single parent homes, and lack of medical care, health and education focused home visitation programs can have a dramatic impact on reducing risks, increasing protective factors, and improving outcomes for both children and their parents. When the same risk factors are accompanied by mental illness, substance abuse, or family violence, however, success rates of these health or education focused programs are much lower. For this reason we began to develop a community based early intervention and prevention program that targeted support for families experiencing multiple risk factors.

Figure 1
Age of Children Entering System of Care



Systems Lessons for Early Intervention

In our effort to build systems of care for high risk families that include very young children, the communities of Southeast Kansas have taught us some critical lessons: 1) Systems of care for young children are very different than the ones for children and adolescents with severe emotional disturbance; 2) Collaboration is worthwhile but hard work; and 3) Good program evaluation improves collaboration, service effectiveness, cost efficiency, and sustainability.

Lesson 1: Systems for young children are different.

Systems of care for young children are different than those for older children and adolescents with serious emotional disturbances (SED). A basic difference is with the service providers and informal supports. The primary service providers in the system of care for older children are education, special education, social services, juvenile justice, and mental health. For families with younger children other providers are prominent, and there are many more of them. Figure 2 shows an organizational listing of the agencies and organizations that provide home visiting for families with young children in our rural communities. There are many programs, however each individual program provides a very limited amount of support. The end result is that supports are fragmented, hard to

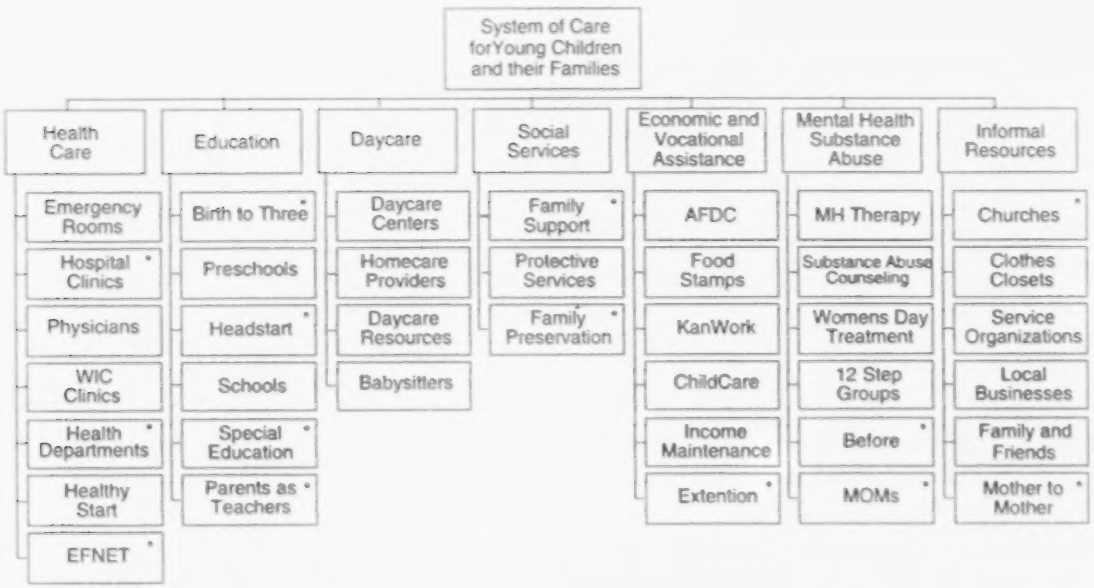
access comprehensively, and inefficiently organized. For example, there are at least 14 separate home visiting programs (note programs with asterisks in Figure 2). In our work we have found families who were receiving home visiting services from as many as six separate programs. The families may not want all these people in their homes, and multiple visitors clearly can be both ineffective and cost inefficient.

The second difference is the priority outcomes for children and families. For families with older children with SED, the focus is on the child. For families with very young children the priority outcomes are safe environments and adequate nutrition, health care, child care, and financial support. The focus for families with very young children is most often the parent(s). For these reasons the planning process must be different. Project KanFocus uses a wraparound approach for all service plans. For the early intervention process, it is meaningful to describe this process as a "whole family" wraparound. While the intent of the wrap-around plan for a child or adolescent with SED is to include the family, the focus of the plan is clearly on the child. In the whole family process, however, the focus is on the family and often the priority areas relate to the parent(s).

Lesson 2: Collaboration is worthwhile, but requires hard work.

The second major lesson from the village is that collaboration is worthwhile but hard work. To provide effective services for children and adolescents with SED, it is important for service providers to coordinate their efforts with each other and with the family. As we began to become involved in this collaboration effort, we saw three levels of ongoing coordination. At one level we would attend meetings when coordination consisted of various agencies telling each other what they did and then planning a joint luncheon to improve communication. At

Figure 2
Organizations Providing Services to Families



*= provides home visiting services

another level, collaboration might be a Part H coordinating council going a step further by publishing a combined calendar of events, planning a joint child find, or a parent's university. The highest level of coordination occurred when a number of agencies worked together to write a joint grant that gave money to each to provide their own categorical services. Clearly these were important steps toward collaboration, but more was needed. Over the past two years we have found strategies and practices that both seemed to improve and hamper collaboration. From these efforts, some lessons from the village on improving collaboration are presented below.

Know the village first. Before developing programs or offering suggestions, it is important to understand the current status of families in the community, the resources to support these families, and the current gaps in services. It is important to know the people and organizations that already provide early intervention support. By knowing the status and needs of the families and children and the strengths of the current providers, it is possible to develop a program that best meets the needs of the children and families while gaining the most acceptance from the community. There are a lot of people out there doing good things and building on these strengths results in a better program.

Once you begin to "know the village," the second general lesson is to ***bring food to the table***. If it is a new service, find a new source to fund it. Try to include funds that will support collaboration efforts. We have found that literally providing food with cross training improves attendance. Joint planning and Continuing Education Units for cross training activities increases turnout. When grants or projects include flexible funds, establishing an interagency coalition to handle these funds increases buy-in to the program.

Joint planning and follow through on individual plans ***build collaboration and trust, one family at a time***. Successfully working together on individual plans builds trust between community supports and expands collaboration possibilities. We have also found that successful collaboration is improved by building and focusing on the big system of care. By looking at how people and communities work together to support all children, programs look past their potentially narrow focus and join each other more easily.

Lesson 3: Program evaluation improves the system.

The third lesson from the village is that program evaluation can improve collaboration, program effectiveness, cost efficiency, and sustainability. By setting goals for KanFocus that are meaningful to the community and reporting on the goals, we have seen greater buy-in. The four primary outcomes developed through the advisory committee and focus groups early in the project were to (a) ensure appropriate health care for the children and mothers; (b) ensure support for substance abuse and mental health needs for parent(s); (c) reduce the risk factors; and (d) support the development of protective factors for the children.

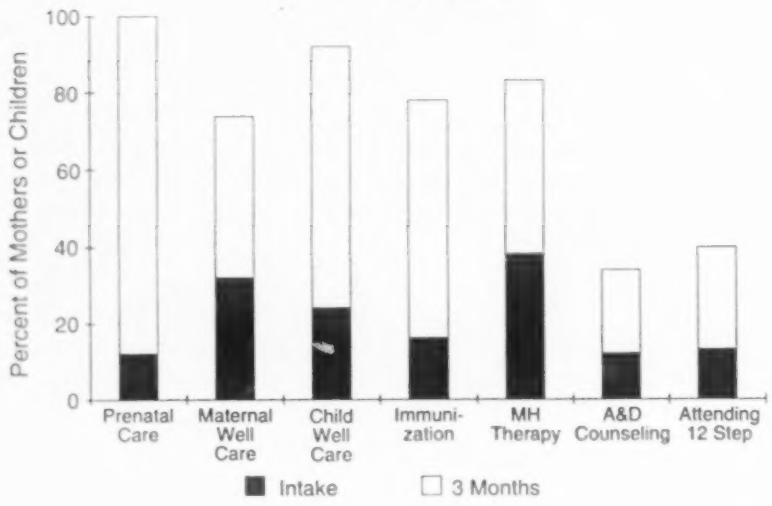
Information on positive outcomes increases community support. As the project has progressed we have measured these outcomes and reported them to the community on a regular basis. We have seen some significant outcomes for our families in all of the primary goal areas (see Figure 3). These data demonstrate the success of the approach, and consequently improve collaboration with our health care partners. Traditionally the health focused home visitors have had difficulty engaging families with significant mental health and substance abuse issues. They were resistant, however, to referring them to the "mental health" program. One key

reason was a fear the families would not receive needed health care services. Figure 3 shows data on health and behavioral health service utilization for families served by the KanFocus project. The black section of each column shows the percentage of children or parents receiving that service at intake. The white section shows the increase at the end of three months. Sharing this health care utilization data showed health care providers that not only are we sincere in our statement of health care as a primary goal, but that we were more successful getting these families to utilize that care than they have been. This has led to many more referrals and improved collaboration.

Our second priority goal is to get parents needed substance abuse and mental health services. We have seen that the care givers in the program are assessing mental health therapy, alcohol and substance abuse counseling and 12 step programs more frequently. Over a third of the women started or restarted therapy and over half became active with one or more of these supports. This is in addition to the ones already receiving services. We have shared this data with the community and with state administration and legislature funders. The response by state funders was both the passage of a children's initiative that includes an early intervention service and approval to use the state's Medicaid plan service for adult case management to fund some of these services.

In addition, program evaluation has revealed unexpected results that have improved community support. Although there was no stated project goal to impact parent employment, we recorded data on employment as both a demographic and risk factor. The Wraparound process asks the family to set the goals. Women targeted by our project were reputed to be the most challenging for job placement programs, however once these women found a safe environment and met basic needs for their children and themselves, they wanted to go to work. Within three months over 75% of them had (see Figure 4). This has built strong local and state support.

Figure 3
Families Recieving Health-Related Services at Intake and 3 Months



Improved staff performance. Program evaluation efforts also have resulted in improved performance by staff. One aspect of program evaluation and quality improvement is monitoring goals from the individualized family plans. Reviews of these plans revealed few goals that directly addressed the development of protective factors for the children. It appeared that the home visitors were so engrossed in helping families meet basic needs that the needs of children were being put off. We determined that it is critical to provide some focus on the children from the beginning because children will not wait.

While their needs are ignored they just grow right past them. This caused us to re-evaluate and change the overall planning strategy, to include specific goals for children in all plans.

Program refinement. The program evaluation process also resulted in changes in the program's eligibility criteria. First, examination of demographic data showed that mental health and substance abuse criteria were being used very loosely. This resulted in families being served who would have been more appropriately served by other providers, while people with severe mental health and substance abuse problems were placed on a waiting list. The case review portion of program evaluation identified this situation and it was corrected.

Capacity building. Program evaluation also looks at community resources to meet identified needs. For example, this assessment spotlighted the before mentioned fragmentation and inefficiency of home visiting services across agencies. This evaluation has been a primary impetus to the development of collaboration in three of the four counties to form integrated family resource centers, with efforts underway to explore ways to reorganize services in a more coordinated fashion. The village is teaching us many lessons. The most important is to listen.

Figure 4
Single Female Caretakers Working or Going to School